State of Connecticut: Implementation Support for State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees

A. Proposed Approach

Connecticut's Demonstration to Integrate Care for Medicare-Medicaid Enrollees seeks to enable person-centered, multi-disciplinary care coordination that will impact both Medicare and Medicaid services and programs by reducing unnecessary areas of over-treatment and/or duplication, addressing areas of unmet need, *and* integrating medical, behavioral, supplemental and social services to promote a healthier population of Medicare-Medicaid Enrollees (MMEs). The Demonstration has been developed via a partnership among the Departments of Social Services, Mental Health and Addiction Services, Developmental Services, the Office of Policy and Management, and diverse stakeholder members of the Complex Care Committee of the Medical Assistance Program Oversight Council.

A.1.1. Overall Implementation Strategy and Key Implementation Tasks

Connecticut will integrate non-medical, medical, and behavioral Medicare, Medicaid, and supplemental services for MMEs through two models that will rest upon the building blocks of its existing Medicaid and long-term care re-balancing reforms. These building blocks include 1) use of medical, behavioral health, dental, and Non-Emergency Medical Transportation Administrative Services Organizations (ASOs); 2) Person-Centered Medical Homes (PCMH); and 3) the Connecticut Long-Term Services and Supports Rebalancing Strategy.

Model 1 – Enhanced Administrative Services Organization (ASO) - Implementation Strategy

Model 1, which will serve all MMEs who are not enrolled in **Model 2,** will support integration on behalf of MMEs by 1) expanding and tailoring the current Intensive Care Management (ICM) and care coordination capabilities of Connecticut's medical ASO, CHNCT, to meet the needs and preferences of MMEs; 2) integrating Medicare data within existing CHNCT Medicaid-focused predictive modeling and data analytics; and 3) enhancing provider use of that data through a provider portal that allows service providers to access data on services provided to MMEs.

Both models will retain the current fee-for-service payment structure for all covered Medicaid services, and will also incorporate a PMPM payment to qualified Person-Centered Medical Home (PCMH) practices that serve MMEs (the **APM I payment**). The Department will convert its current enhancement of fee-for-service payments to a PMPM, effective with the start of the Demonstration period.

Model 1 - Key implementation Tasks

Key implementation tasks for Model 1 include 1) expanding CHNCT care coordination staffing capacity to provide Intensive Care Management to high-risk MMEs newly identified via predictive modeling; 2) ensuring that CHNCT care coordination and member services staff receive Demonstration-specific training on person-centered, goal-directed, disability competent care planning and member support; 3) revising and expanding the existing CHNCT care plan assessment tool and protocol consistent with the common functional assessment tool developed by Connecticut for purposes of the State Balancing Incentive Payments Program (BIPP) and best practices for care coordination on behalf of MMEs that have been identified by Department staff

through a literature search and inventory of best practices; 4) through contractor JEN Associates, establishing use agreements and protocol for CHNCT use of integrated Medicare and Medicaid data for predictive modeling purposes; 5) review and refinement of the current predictive modeling process to tailor it for use with MMEs; 6) establishment of agreements for use of CHNCT provider portal as a means of enabling provider access to data on utilization of services by MMEs; 7) development of member outreach and education materials; and 8) development of an integrated Medicare and Medicaid grievance and appeals process and strategy for incorporating an ombudsman function. A detailed depiction of staff involvement in, anticipated timelines and key components each of these tasks is provided in the Implementation Plan in Appendix ___.

Model 2 – Health Neighborhoods (HNs) - Implementation Strategy

Model 2 will launch a new local, person-centered, multi-disciplinary provider arrangement called the Health Neighborhood (HN). This model will focus upon local accountability among providers working together consistent with a MME's values and preferences through connections that will include care coordination agreements and electronic communication tools, to achieve better integration. Model 2 will offer supplemental services that are not currently covered under the State Plan or a waiver including, 1) chronic disease self-education and management; 2) medication therapy management; 3) nutrition counseling, 4) falls prevention; and 5) peer support and recovery assistance. MME participants of HNs who are served by the Connecticut mental health waiver currently have access to peer support and recovery assistance; therefore, they will not be eligible for those supplemental services under the Demonstration

Each HN will be organized by an Administrative Lead Agency (ALA), which will contract with a Behavioral Health Partner Agency (BHPA) and a broad range of providers, including Lead Care Management Agencies (LCMAs) that will provide comprehensive care coordination services to MMEs. MMEs will be passively enrolled in HNs based on affiliation with an HN provider member from whom they have received healthcare services. MMEs will have the right to opt out of participation in an HN. Those who remain enrolled with an HN have the right to see any Medicaid provider of choice, irrespective of whether that provider is a member of the HN.

Each MME who remains enrolled in an HN will select a Lead Care Management Agency from a range of qualified LCMAs within the HN and a Lead Care Manager (LCM). This Lead Care Manager, an employee of the LCMA, will be the single point of accountability for coordinating the care for the MME. The LCM will coordinate with the full range of each MME's providers as well as existing, service-specific sources of care coordination including, but not limited to, waiver care managers, Local Mental Health Authority (LMHA) case managers, and Money Follows the Person (MFP) transition coordinators.

Model 2 will introduce additional payments over and above the current fee-for-service arrangement under Connecticut Medicaid. These will include start-up payments to HNs, a PMPM payment for care coordination (the **APM II payment**), and, if savings are achieved under the demonstration, performance payments. Additionally, Model 2 will incorporate the APM I payments to qualified PCMH practices that are referenced above.

Connecticut will require HNs to satisfy and build upon threshold standards for all aspects of the team-based care coordination model.

- **Each HN will be required to demonstrate participation by a required set of provider members**, and may also build upon these standards by incorporating participation by other adjunct participant members.
- **Each HN will also be required to enter into standard care coordination agreements** (provided by the State of Connecticut) with all member providers, which will detail terms including, but not limited to: 1) means of communication between MMEs, Lead Care Managers (LCMs), primary care, specialists and other providers; 2) means of consultation among MMEs, LCMs and members of MMEs' multi-disciplinary care teams; and 3) role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).
- **Further, HNs will be required to indicate the means through which each Administrative Lead Agency will ensure that provider members receive training** to support: 1) communication and connections across disciplines; 2) specific expectations for the care coordination process; and 3) strategies to address care coordination challenges, including, but not limited to, care transitions, urgent scenarios and situations that involve co-occurring conditions.
- **Additionally, HNs will be required to affirm that they will fulfill the minimum standards for care coordination established by Connecticut**. These enumerated Proposed Minimum Care Coordination Standards for the Integrated Care Demonstration address topics such as: 1) standards for enrollment and choice of Lead Care Manager; 2) required information disclosures; 3) the initial assessment process; 4) selection and

composition of the members of each multi-disciplinary care team, especially in situations in which there is another source of care coordination support (e.g. a waiver care manager, LMHA case manager or MFP transition coordinator); 5) development with the beneficiary of a Demonstration Plan of Care; 6) guidelines for implementation, and revision, of Plans of Care; and 7) standards for the level of assistance to be provided by Lead Care Managers. The type and frequency of care coordination support that an LCM is providing to each MME will be informed by the level of care coordination support that the MME requires.

- Finally, **HNs will be obligated to ensure that participants of the Demonstration are afforded various procedural protections** in the care coordination process that include the beneficiary acting as the focal point of all Demonstration-related activities, choice of Lead Care Manager, right to switch Lead Care Managers, right to switch Lead Care Management Agency, right to participate in care planning and development/approval of Demonstration Plans of Care, and right to file a grievance in situations in which beneficiaries do not agree with the terms of a Plan of Care.

Model 2 - Key implementation Tasks

Key implementation tasks for Model 2 include 1) review by stakeholders and finalization of operating plan documents outlining requisites for Health Neighborhood (HN) leadership, structure, provider and other membership, and care coordination; 2) development and issuance of a Request for Proposals (RFP) in support of procuring three to five (3-5) Health Neighborhoods; 3) provision of technical assistance to applicant HNs including strategies for brokering across provider disciplines, "cluster analyses" created from integrated Medicare and Medicaid data that

illustrate current hubs of service to MMEs, and anti-trust guidance; 4) selection of HNs and negotiation by the Department of Social Services of contracts with each HN's Administrative Lead Agency (ALA); 5) execution of care coordination contracts between ALAs and provider members of HNs; 6) finalize CHNCT activities to use integrated Medicare and Medicaid data to inform passive enrollment of MMEs in Model 2 and also to assign MMEs to risk categories for purposes of the APM II payment; 7) define Xerox activities to develop enrollment systems, develop enrollment policies and procedures, support enrollment activities, and receive and communicate MME enrollment information to the MMIS and/or HNs; 8) execution of a contract between each ALA and the identified Demonstration Electronic Health Record (EHR) swipe card vendor and development of a protocol for use of the cards; 9) development of member outreach and education materials and engagement of community partners to inform MMEs about HNs; 10) identify, test, and implement MMIS changes in support of provider and client enrollment, and payment of the HN and its providers/LCMAs; and 11) development of provider learning collaborative curricula and implementation schedule. A detailed depiction of staff involvement in, anticipated timelines and key components each of these tasks is provided in the Implementation Plan in Appendix ___.

A.1.3. Stakeholder Engagement

The Department, as well as partners DMHAS and DDS, have continued to engage monthly with the Complex Care Committee (CCC) of the Medical Assistance Program Oversight Council (MAPOC). The CCC is composed of a broad range of stakeholders including consumers, providers, and advocates. MAPOC has broad statutory authority to review and comment on the Connecticut Medicaid program, and the CCC has reviewed and offered input on every aspect of

development of plans for implementation of the Demonstration. This will continue ongoing. Additionally, MMEs and other stakeholders will be instrumentally involved through focus groups and advisory work groups in many aspects of implementation, including, but not limited to, development of beneficiary education and outreach materials, drafting and application of the Demonstration care coordination training and learning collaborative curricula, and design of the integrated grievance and appeals process.

B. Organizational Capacity

B.1.1. Infrastructure/Capacity of State Medicaid Agency

The Department of Social Services is well qualified to implement an innovative model to address the care coordination needs for the MME population. In 2012, the Department operated within a $6.5 billion annual budget of which over 80% supported the operation of health care programs including Medicaid (Title XIX), CHIP (Title XXI), ConnPACE (pharmacy assistance), CT AIDS Drug Assistance Program (CADAP), and numerous state-funded programs including the Charter Oak Health Plan. Through all of these programs, DSS provides health care to 20% of the 3.5 million residents in the State of Connecticut.

In 2012, Connecticut Medicaid transitioned to a unique managed fee-for-service approach under which an organization that was formerly contracted as a Managed Care Organization (MCO) provides managed fee-for-service benefits to the entire Medicaid program as an Administrative Service Organization (ASO). This model offers the Department the opportunity to implement the demonstration with reduced administrative costs while ensuring strong fiscal and policy

oversight to maintain provider accountability and member benefit protections without the intermediate contractor level formerly occupied by the MCOs.

The Department will be accountable for implementation and oversight of the Demonstration, and will partner with sister agencies DDS and DMHAS in further development and monitoring of the Demonstration. Key areas of internal support include the Division of Health Services (DHS), the Division of Financial Management & Analysis (DFMA), the Office of Legal Counsel, Regulations and Administrative Hearings (OLCRAH), and the Office of Organizational Skill & Development (OSD). Overall direction in developing and implementing the Demonstration will be provided by a Steering Committee, including representatives from state agencies (DSS, DMHAS, DDS and OPM) and other key stakeholders including consumers and consumer representatives. The Steering Committee will also engage with MMEs and others through such means as focus groups and community town halls to support participation in and feedback on administration of the Demonstration.

B.1.2. Staff

The Project Manager for the Connecticut Duals Demonstration will be Kate McEvoy, JD - the Interim Director of the Division of Health Services at the Connecticut Department of Social Services. Ms. McEvoy has been in her present position since August, 2012 and on staff at the Department since January, 2012. Prior to joining the management team at DSS she served as an Assistant Comptroller with responsibility for health care policy, and previously had over 20 years of experience in the health care field in Connecticut as an advocate.

Supporting Kate in Project Management at DSS will be a full-time Project Director (TBD). Four new positions will be created to support program implementation – a project coordinator, project assistant, and two fiscal analysts. Additional support from existing staff (not requested in the budget) will be available from the Director of Behavioral Health, the Medical Operations Divisions (Enrollment and the MMIS), the Office of Legal Counsel and Regulatory Affairs (Grievance, Fair Hearings, and Contracts) and the Division of Fiscal Analysis (Budget and Federal Claiming). See Staffing Chart in Section D. The Department commits to maintaining sufficient organizational resources, including staff, information technology and capacity to provide oversight of the Demonstration and also to track data required for semi-annual progress reports to CMS.

B.1.3. Contractors

The Department intends to use both contractors that are currently in place and new contractors to support activities of the Demonstration. These include the following:

JEN Associates (current) will continue to act as the integrator of Medicare and Medicaid data for the Demonstration. JEN has well recognized expertise in this work, and performed the initial integration and cluster analysis during the planning phase of Connecticut's Demonstration work.

An actuarial consultant (TBD) will refine the initial calculation of the APM I and APM II payments, develop Demonstration cost savings projections, and design a model for the performance payments that are proposed to be made in Model 2. The actuarial consultant is anticipated to be secured from within the current array of state contractors.

HP (current) will provide support functions for both Demonstration models. Under Model 1, through the MMIS, HP will continue to be responsible for all state plan and HCBS waiver fee-for-service payments, and will be responsible for the enhanced care coordination payments (APM 1) made directly to the designated patient-centered medical homes (PCMH) for the delivery of enhanced primary care to the MME population. Under Model 2, HP will be responsible for making fee-for-service state plan and waiver service payments and for making Demonstration care coordination payments (APM 2) to Lead Care Management Agencies (LCMA) in the HNs. These payments will differ from the APM 1 payments by procedure code and content. Hewlett Packard (HP) and its predecessor (EDS-Electronic Data Systems) has been the incumbent MMIS contractor since the first certified system in 1985. In the managed fee-for-service model, the MMIS is the means by which provider claims are adjudicated and cost and utilization data is provided to the Department and CHNCT.

Xerox (current), formerly ACS, through a contract amendment, will provide enrollment services under this Demonstration, including the operation of a call center, the production and distribution of member notices, enrollment of MMEs in Model 1 or 2 of the Demonstration, and documentation of MMEs' selection of LCMs. Xerox has had a long and successful relationship with the Department as an independent enrollment broker dating back to the inception of managed care in 1995.

A performance evaluation consultant (TBD) will support activities including review and refinement of the Demonstration performance measures and development and implementation of

the additional evaluative activities (e.g. population- and diagnosis-specific studies) outlined in Section C. The performance evaluation consultant is anticipated to be procured as a sole source contract with an academic partner with considerable expertise and experience in this area.

An entity with expertise in connecting providers across disciplines (TBD) will perform that role in support of entities seeking to be selected as HNs during the RFP process. This consultant is anticipated to be procured as a sole source contract with a partner with considerable expertise and experience in this area.

An Electronic Health Record (EHR) swipe card vendor (TBD) will provide system support and embossed paper card functionality for exchange of MME-specific care plan data under Model 2. This consultant is anticipated to be procured as a sole source contract with a partner with considerable expertise and experience in this area.

CHNCT (current) will continue to act as the Medicaid program's medical services Administrative Services Organization (ASO). CHCNT will provide member services, inform Xerox regarding passive enrollment of MMEs in HNs, conduct predictive modeling, analyze expenditure and other data, provide utilization management functions for Medicaid services (e.g. prior authorization), and according to Demonstration standards provide care coordination to MMEs who are not enrolled in HNs. CHNCT was previously contracted with the Department as a managed care organization and was awarded the ASO contract effective January 1, 2012. CHCNT has a full complement of qualified staff supporting each of the above functions. Note that **Value Options** and **BeneCare** will respectively continue to act as the Medicaid program's

behavioral health and dental ASOs. Value Options will coordinate with CHNCT to support MMEs with co-occurring behavioral health conditions. BeneCare will continue to provide member services and referral functions.

B.1.4. Implementation Plan

Please see Appendix ___ for Implementation Plan.

C. Reporting and Evaluation

C.1.1. Plan for Collecting and Producing Data in Support of Progress Reports

The Department agrees to collect and produce the data and analysis of the cooperative agreement activities for the semi-annual progress reports that will be provided to CMS. These will include an analysis of challenges, discussion of best practices or key lessons, provision of mitigation strategies for addressing implementation barriers, and substantiate source of state funding share (in year 2). The Department also agrees to collect and provide data to CMS to inform program management, rate development and the calculation of shared savings with the HNs including but not limited to: 1) beneficiary-level expenditure data and covered benefits for most recently available three years; 2) a description of any changes to the State plan that affect MMEs during the Demonstration period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and 3) State supplemental payments to providers (e.g., DSH, UPL) during the three year period. Further, the Department will collect data and report to CMS on the performance measures identified in Appendix ___. The Department will fully cooperate with the operations support, actuarial rate-setting services, and evaluation contractors in reporting data

that they may require for Demonstration evaluations. Further, as indicated above, the Department will contract with a performance evaluation consultant in order to perform program evaluation.

The Department has a robust reporting structure in place under the contract with HP to operate the MMIS. Further, CHNCT will be responsible under contract to the Department to report the above expenditure data to the Department. The Department will be responsible for reporting any changes to the State plan and also State supplemental payments to providers.

D. Budget and Budget Narrative

D.1.1. Budget

See Appendix ____ for Budget.

D.1.2 Budget Narrative

In the budget provided in *Appendix A – Budget*, Connecticut has displayed projected Demonstration-related costs as fully funded under the demonstration grant (100%) in the first year and 75% in the second year. This support is essential to fulfilling our stated intention in administering this Demonstration.

Much of the original intent regarding reimbursement has been retained from the original application. This includes the start-up payments to HNs, the proposed APM I payments and the structure for performance payments. Connecticut has based on stakeholder feedback and internal review, however, revised two aspects of the original design of the APM II payments. First, these

payments no longer include the supplemental services. Payments for supplemental services will instead be made to the Administrative Lead Agency of each HN, which will indicate in its contract with the Department how these services will be selected and procured. Second, APM II payments will be made through HP directly to Lead Care Management Agencies and not, as originally contemplated, to the HN Administrative Lead Agencies.

The State intends to submit a combination of State Plan Amendments, and also potentially waivers, to support both APM I and APM II and to ensure the viability of the reform in future years. The statutory authorities that Connecticut is considering include PCCM under the State Plan, 1915 (i) option under the State Plan, and use of, or combination of, 1915 waiver authorities.

In the design of the budget for both the Demonstration and the State Plan vehicles for the APM I and APM II funding, the State is aware of the potential for service and cost duplication with both the existing Home- and Community-Based Services Waiver and the reintegration services provided by Connecticut's successful MFP program. In the first instance, it will be the responsibility of the care coordinators in APM I and APM II to orchestrate the POC so that any potential duplication does not occur. In the case of MFP, we believe that there are opportunities for productive linkages between the transitional services provided under MFP for individuals leaving the institutions and receiving supplemental services provided to the MMEs enrolled in the HNs in Model 2.

Staffing

Name	Title/Division	Role and Responsibilities	Qualifications	% time/hrs. per mo.
Kate McEvoy	Interim Director/ Division of Health Services (DHS)	Overall project oversight including procurement, contracting, performance and quality assurance	Twenty years of experience in health policy and long-term services and supports	10%/16
Uma Ganesan	Associate Director/ DHS	Oversight of reimbursement and financial reporting	Ten years of experience of financial management experience with private payer	10%/16
TBD (New hire)	Project Coordinator/DHS	Day-to-day project lead, liaison to ASO and HNs as well as Department staff	Hiring criteria will include project management, program development and quality assurance experience	100%/160
TBD (New hire)	Assistant Program Coordinator/DHS	Assistant to day-to-day project lead	Hiring criteria will include project management, program development and quality assurance experience	100%/160
Lee Voghel	Fiscal Director/ Division of Finance Administration (DFA)	Oversight of project budget and Federal reporting	Long tenured director of Department financial management	10%/16
TBD (New hires)	2 Fiscal Analysts/ DFA	Support for project budget and Federal reporting	Hiring criteria will include budget drafting and reconciliation, Federal reporting experience	100%/160
Mark Heuschkel	Medical Operations Manager/DHS	Oversight of MMIS and lead liaison to HP	Experienced director of Department's MMIS responsibilities	10%/16
Sandy Ouellette	Medical Operations Supervisor/DHS	Support with MMIS and liaison activities with HP	Experienced manager in medical operations	10%/16
Rivka Weiser	Health Program Assistant II/DHS	Project Coordinator	Performed lead support role in development of program design	75%/120
Judi Jordan	Director of Medical Care/DHS	Department lead liaison with CHNCT	Director with extensive contracting and performance monitoring	10%/16

			experience	
Kristin Dowty	Manager/DHS	Department lead liaison with Xerox	Experienced manager with lead liaison responsibility	10%/16
William Halsey	Director of Behavioral Health/ DHS	Department lead liaison with Value Options, DMHAS and DDS	Director with extensive BH clinical care coordination experience	25%/40
Dr. Robert Zavoski	Medical Director/DHS	Support to project with overall performance monitoring	Physician with extensive applied clinical and policy experience	10%/16
Kathy Bruni	Manager of Alternate Care Unit/DHS	Support to project with performance monitoring on care coordination	Manager with extensive applied clinical care coordination experience	10%/16
Contractors	a. JEN Associates b. Actuarial Consultant c. HP d. Xerox e. Program Evaluation Consultant f. EHR Swipe Card Vendor g. CHNCT	a. Data integration b. Review and refine PMPM payments, calculation of savings projections c. MMIS reimbursement d. HN member outreach and enrollment functions e. Review of performance measures, analysis of performance using identified methods f. Provision of electronic health record cards and	a. Experienced b. Engagement criteria will require relevant experience c. Long-tenured current Department contractor d. Long-tenured current Department contractor e. Engagement criteria will require relevant experience f. Engagement criteria will require relevant capability	

		platform g. Member services, data analytics, and Model 1 care coordination functions	g. Current Department contractor	

Section B6(a) Personnel, (b) Fringe Benefits, and (e) Supplies

The implementation and operation of the HNs will require significant investment by existing staff at DSS and the addition of two (2) new full-time project positions, including a project coordinator, who will oversee the Demonstration and will also be responsible for coordinating with the managers for the supporting contractors (CHNCT-Model 1, HP-MMIS, Xerox-enrollment). In addition, two (2) new financial analyst positions will be created and dedicated full-time to the project to support program oversight, financial reporting, and the monitoring of estimated savings. Fully loaded staff costs, including fringe benefits, are detailed in Appendix A – Budget. In addition, the State will provide, directly to consumers, marketing materials to promote awareness and convey the benefit of participation in the Demonstration.

Section B6(f) Contractual Costs (subcontracted services)

An array of new and existing contractors will provide and support services for the project. Below are brief descriptions of partner activities supporting the Demonstration. A more detailed fiscal impact of these relationships is included in the budget.

1. JEN Associates: JEN Associates will be responsible for the creation of the linked Medicare-Medicaid dataset in both Year 1 and Year 2. JEN Associates will also provide a cluster analysis to support identification of potential Model 2 enrollees.

2. Mercer: Mercer will provide actuarial services in calculating the rates for APM 1, APM 2, and the shared savings model.
3. Hewlett Packard: HP will provide the requirements definition, configuration, testing, implementation, and operations for the MMIS system changes necessary to support payment, as well as client and provider enrollment and the required federal financial reporting.
4. Xerox: Xerox will provide the client enrollment services to potential Demonstration enrollees based on the JEN Associates data, and modify their enrollment system in order to process client enrollment in the Demonstration.
5. Performance Measures and Program Evaluator (TBD): this partner will conduct performance assessments of HNs against contract standards for care coordination and will oversee program evaluation for both models in the Demonstration.
6. Design assistance for the HNs: The Department will contract with a quality review organization to provide assistance with HN startup by supporting providers in connecting across disciplines.
7. Electronic Health Record swipe cards: The Department is pursuing a contract with a vendor that will provide member swipe cards that will be encoded with health information that can be read and updated by providers in the HNs.
8. Electronic care coordination tool development: The contract amendment with CHNCT will include funds to configure the current predictive modeling tools for the Medicaid population to receive and produce reports based on the JEN dataset for both Model 1 and Model 2.
9. Model 1 ICM - Enhanced ASO, including start up: CHNCT will adapt its current ICM program to accommodate the new MME population it will be taking on as ASO. CHNCT is adapting its current risk stratification procedures to include ICM as a standard practice, as

necessary, for all non-PCMH, non-HN enrolled MMEs. These costs are based on CHNCT staffing costs estimates related to providing ICM services to approximately 1,600 members with intensive health care needs. During the Demonstration, CHNCT will staff one (1) ICM Director, fifteen (15) Intensive Care Managers, and eleven (11) ICM support staff.

10. Health Neighborhood costs: The Department will provide start-up grants of $250,000 to up to five (5) HNs that will be created as a result of the competitive procurement. Each HN will receive approximately $105,000 per year to support administrative activities. In addition, each HN will receive approximately $250,000 to provide supplemental services to HN enrollees over the two-year grant period. The supplemental service costs were derived using the full Model 2 potential enrollee estimate, a penetration rate to estimate those that will actually present for a particular service, and caseload ratio. The full enrollee estimate of need was then divided by the number of HNs.